Remarks of

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SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

to the

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Good morning, and thank you for this opportunity to speak to you this morning. I've been asked to talk about my Subcommittee's agenda for this year, and about future directions in managed care policy.

We have a very busy schedule this session, made all the more hectic by the fact that we will probably adjourn early for elections. In addition to the usual business of hearings and mark-ups on new legislation and reauthorizations of existing programs, there are some major areas of priority I think we need to focus on, and this is what I'd like to talk to you about.

First, I am very concerned about various proposals that shift the burden of deficit reduction to the elderly and disabled under the Medicare program. It's time to stop and evaluate the broad-scale cuts that we've made over the last several years, and continue with the reforms that will make the system operate more efficiently.

Second, we need to put more resources into the Medicaid program. Our nation is still badly underinvested in the health care of its low-income mothers and children.

Third, we need to pay for AIDS treatment costs. Having missed our opportunity to pay for the ounce of prevention, we now have to pay for the pounds and pounds of cure.

Finally, we need to take some concrete steps towards comprehensive health care reform. It is unacceptable that 31 to 37 million Americans have no coverage for basic health care needs.

Medicare

Let's take a closer look at the Medicare picture.

The President has proposed to cut Medicare spending by $5.5 billion next year. His budget includes reduced payments for hospital services, lower fees for physician services, and reductions in both coverage and payments for other diagnostic and therapeutic services.

Will these proposals improve the effectiveness of the Medicare program? No. Their primary purpose is deficit reduction. Their effect is to jeopardize the availability and quality of health care for our nation's elderly and disabled.

We should think very carefully before we extend the types of freezes and reductions we have been churning out over the last several years, since we have so little reliable information about their effects on access and quality of care so far.

Over the last eight years, the Congress has adopted major reforms, as well as piecemeal savings proposals, that total more than $40 billion in expenditure reductions in Medicare. One of the most promising -- and controversial -- reforms that we have struggled with is the concept of physician payment reform.

Last year saw the culmination of several years' work on RB RVS payment reform in Medicare and the creation of a Federal outcomes research/clinical practice guidelines program.

I do not expect anything comparable this year. Instead, we will be monitoring the implementation of these two major initiatives. As I mentioned earlier, I am going to make every effort to assure that these reforms are not undermined by arbitrary Medicare budget cuts.

We are hearing more and more concern being expressed bout how the Medicare program affects patients and physicians. Issues are being raised regarding quality of care, utilization review, and other administrative requirements.

The Institute of Medicine has recently released an important study, requested by Congress, which proposes major changes in the quality assurance for the Medicare program. I expect that my Subcommittee will want to explore this in some detail.

Last month, the Subcommittee held a hearing in Atlanta which highlighted some of the concerns about the administration of the Part B program by the carriers. This will continue to receive the attention of the Subcommittee.

It's obvious that the Medicare physician payment reforms will significantly change the environment within which physicians practice medicine. There will be changes in the methods for payment. There will be changes in the amounts of payment. And the program will begin to focus on what its is paying for, and under what condition services are being furnished.

As we move to a system of administered prices, Medicare will have to be more careful in defining what is included in, or excluded from, the service for which the price has been established.

The bottom line is that some physicians will be receiving lower revenues from Medicare, while other physicians will receive more. But all physicians will be more closely monitored by Medicare in how they practice medicine.

I supported both the RB RVS payment reform and the development of clinical practice guidelines and medical review criteria. But I continue to have serious misgivings about the so-called "volume performance standards," which were adopted at the insistence of the Bush Administration.

As you know, these are targets for the total expenditures for physician services under Medicare for a twelve month period. If total expenditures exceed the target, then the annual update in physician fees two years later is reduced. The target for this year has been set at 9.1 percent. It is almost certain to be exceeded, and two years from now payments will be reduced accordingly.

We have put the cart before the horse. We have established the target, retroactively, before the physician community has the tools to monitor itself and work cooperatively to reduce the rate of increase. Physicians who are delivering appropriate care will face the same financial penalty as those who are abusing the program, yet there is little that the responsible physicians can do to protect themselves.

Volume performance standards under these conditions are irrational and unfair. But the budgetary reality is that they will be with us so long as the rates of increase in Medicare expenditures continue to exceed 10 percent each year.

Medicaid

Now let me turn to Medicaid.

Last year we made some progress in expanding the Medicaid program to more low-income pregnant women and young children. That will mean over 800,000 fewer people without health care coverage.

But that leaves well over 30 million uninsured. Obviously, we need to do more.

During the campaign, Candidate Bush promised to extend Medicaid coverage to all pregnant women and infants will incomes below 185 percent of the poverty level. He also promised to extend coverage to all poor children. I want to help him honor his commitment.

We also need to do more to provide long-term care services in the home and community for the frail elderly and for people with mental disabilities. No one should be forced into nursing homes or institutions because they lack access to services where they live. Proposals to eliminate the institutional bias in the Medicaid program passed the House last year, and I am hopeful that this year they will see enactment.

And we need to do more to provide preventive services to people who are infected with HIV. No one should be forced to get AIDS simply because they can't afford the drugs to prevent it. To that end, I have introduced legislation that would get early intervention drug services to poor patients while such services are still useful and assist those hospitals that are struggling with an overwhelming case load of AIDS patients who depend on Medicaid.

Let me elaborate a bit on why such legislation is needed. Right now, poor people with full-blown AIDS can qualify for Medicaid assistance. Poor people who are infected and have a deteriorating immune system--but who don't yet have full AIDS--cannot. That means that Medicaid will pay when people need expensive inpatient care to treat pneumonia but won't pay when they need drugs to prevent pneumonia. It's a crazy Catch-22 for Medicaid and for the patient. We could prevent sickness, but the only people we help are those who are already sick. Rather than keep people productive, we let them deteriorate. That's stupid---and it's expensive.

There have been 120,000 cases of AIDS in the U.S. in the last eight years, and the health care system in urban areas has been stretched to the breaking point. The Public Health Service estimates that there are one million infected Americans, and that more than half of them have severely compromised immune systems already.

Without some help, many of these people will be unable to purchase the drugs that have been developed to postpone or prevent their illness. Inner-city hospitals are overflowing now. Without some help, they will be overwhelmed. Public hospitals are on the edge now. Without some help, they will be bankrupt.

AIDS

To complement this Medicaid AIDS initiative, this week I introduced legislation to provide Federal funds for testing, early diagnosis, and treatment of HIV infection. Current law essentially pays for only the most expensive and the most extreme measures, waiting until an AIDS patient develops full-blown disease and requires hospitalization. In terms of humanity and in terms of budgets, it makes real sense for us instead to use the drugs that we have developed to slow the progress of the disease and to prevent the pneumonia that accompanies it.

The legislation also provides funds to those high-incidence cities that have been battered by the AIDS epidemic. Clearly those areas--and their public and voluntary organizations--have carried much of the weight of health care services to people with AIDS. Even more clearly, these cities will not be able to continue to do so for the tidal wave of cases that will be coming throughout the Nineties. It will be necessary for the Federal government to help these cities with disaster relief money.

I expect the Subcommittee to hold hearings on both of these AIDS initiatives and to take them up later this spring. The epidemic is not waiting for us to act.

National Health Service Corps

The Subcommittee will be reauthorizing a number of existing health programs. One of particular interest to you may be the National Health Service Corps.

There are about 12.5 million Americans living in areas without primary health care. The problem is not that these Americans are uninsured; many of them have public or private coverage. The problem is that there are simply no primary care doctors or other health professionals serving the communities in which they live. At the same time that over 1900 rural and urban areas are underserved, there are many communities with a surplus of physicians. This is indefensible.

We have a program to address this problem: the National Health Service Corps. Established in 1970, the Corps places physicians and other health professionals in health manpower shortage areas (HMSAs). These practitioners may be volunteers, but for the most part they have an obligation to the Corps as the result of receiving scholarship assistance, or as the result of receiving assistance in repaying loans they took out to finance their professional education.

Unfortunately, due to a bad decision we made in the early 1980's to phase out the scholarship program, the Corps is no longer able to meet the needs of most underserved communities. To eliminate the shortages in all 1,935 HMSAs would require 4,147 primary care physicians. This year, the Corps expects to place 1,751 physicians and other health professionals in HMSAs. That is down from 1,950 placements in 1989. There are currently 123 scholarship recipients available for placement. By 1993, this number will decline to 18.

The logic of these numbers is obvious. Unless we change course, we are never going to meet the need of underserved areas for 4,147 primary care physicians. Unless we change course, 12.5 million Americans in rural and urban underserved areas will never have access to primary health care.

To change course, I joined earlier this week with several members from the Congressional Rural Health Caucus in introducing the National Health Service Corps Revitalization Act.

This bill would make several important changes.

First, it would clarify that the mission of the Corps is to make primary health services available to residents of underserved rural and urban areas.

Second, it would revise and extend the authorization for the Corps field program, providing such sums as necessary to eliminate health manpower shortages.

Third, it would clarify the criteria and procedures which the Department of Health and Human Services (HHS) must use in designating the underserved areas with the highest priority for placement of Corps physicians.

Fourth, it would start up the scholarship program again, by requiring that at least 10 percent of the amounts appropriated each year for scholarships or loan repayments be applied to scholarships, and that at least an additional 5 percent of the total amounts appropriated each year be used to fund scholarships for certified nurse midwives, certified nurse practitioners, and physician assistants.

Finally, the bill would authorize the Secretary of HHS to make grants to States to establish and operate Offices of Rural Health.

I expect the Subcommittee to hold hearings on this legislation later this month, and to proceed to markup soon thereafter.

The Uninsured

Let me conclude this discussion of the Subcommittee agenda with some comments on the 31 to 37 million people in this country who have no public or private health insurance coverage.

Last month, the Pepper Commission, of which I was a member, recommended a $23 billion program to extend basic health care coverage to the uninsured, using a combination of employer-based insurance and a new public program for those not in the workforce. The Commission also proposed a $34 billion long-term care program.

I support the Pepper Commission's recommendations. Even though they are far from perfect, I believe that they would go a long way towards a health care system that provides adequate coverage for all Americans. I hope to hold hearings this year on the legislation that comes from these recommendations. Even if we aren't able to complete legislative action before we adjourn for the November elections, I think consideration of these proposals will move us forward significantly.

Managed Care

Let me close with some remarks on the future direction of "managed care" policy.

As you know, the Bush Administration has made "managed care" a centerpiece of their Medicare and Medicaid budget proposals for this year. They believe that this is, and I quote, "the best means of assuring quality and appropriateness of care."

"Managed care" is one of those buzz words that means very different things to different people. Since we don't have a concrete legislative proposal from the Administration, I don't know exactly what they mean by "managed care," or whether their initiative makes any sense for Medicare or Medicaid beneficiaries.

Here's what I understand by "managed care." Medicare and Medicaid would purchase care from organizations that assume responsibility for the cost, quality, and appropriateness of the services received by the beneficiaries. To me, "managed care" is not just utilization review or claims processing. It is organizing and actually delivering high quality, medically necessary services that improve or maintain the health status of patients.

"Managed care" could include a number of different organizational models. The key point is that the physicians, in making patient care decisions, are not subject to financial incentives that compromise their clinical judgment so that patients do not receive needed care. A "managed care" plan would be carefully organized so that it manages its physician and hospital resources intelligently, using clinical practice guidelines and other quality tools to assure that care is appropriate.

If it is done right, "managed care" can control health care costs more effectively than traditional fee-for-service practice. But it would be a huge mistake for the Federal government to encourage Americans to use "managed care" in order to save large amounts of money. As this audience knows as well as anyone, it costs money to deliver high quality, appropriate care.

What concerns me about the Bush Administration's budget rhetoric on "managed care" is that they seem to want to push the development of alternatives to fee-for-service very rapidly. This would be a prescription for chaos. As you know better than I, it takes time to set up a financially stable, high quality "managed care" plan. We have seen time and time again -- in California, in Arizona, and in Florida -- that the hasty implementation of "managed care" can lead to poor quality care, diversion of government health care dollars, bankruptcy, and racketeering.

It seems to me that there are five elements basic to any responsible "managed care" strategy.

First, patients must always have a choice as to whether to enroll in a "managed care" plan, and should be able to disenroll if they are dissatisfied with the care. Letting patients vote with their feet is still one of the best ways to assure that plans are doing a good job.

Second, the financial incentives under which physicians practice in "managed care" plans must be reasonable. It is wasteful to reward physicians simply for delivering more and more care. But we also have to avoid arrangements under which a physician is penalized financially for providing appropriate care to an individual patient.

Third, we have to develop quality standards and processes so that purchasers of care can satisfy themselves not just that services provided <u>are</u> appropriate, but that services are provided <u>when</u> appropriate. If we're paying for "managed care," then we ought to be sure that the care is in fact managed, and managed intelligently.

Fourth, reimbursement will have to be adequate to allow an efficient, well-managed plan to deliver high quality care, and it will have to be sensitive to the health status of the patients enrolled by each plan. If we underpay for "managed care," we will guarantee that patients do not get services that they need.

Finally, any "managed care" initiative should be implemented slowly, at a pace that the health care delivery system can accommodate.

I look forward to working with your organization on these issues as the "managed care" debate moves into the 1990's.

I'd be pleased to answer any questions.